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Is your organisation stuck in a clinical governance rabbit hole?

How we fall in – and how to get out!

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Declaration of Interest

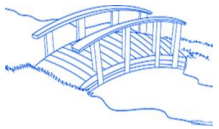
The Australasian Institute of Clinical Governance funded the production of the associated ‘Four Clinical Governance Rabbit Holes to Avoid’ paper that is available via their website.

Today: 30 years of lessons learned in 20 mins

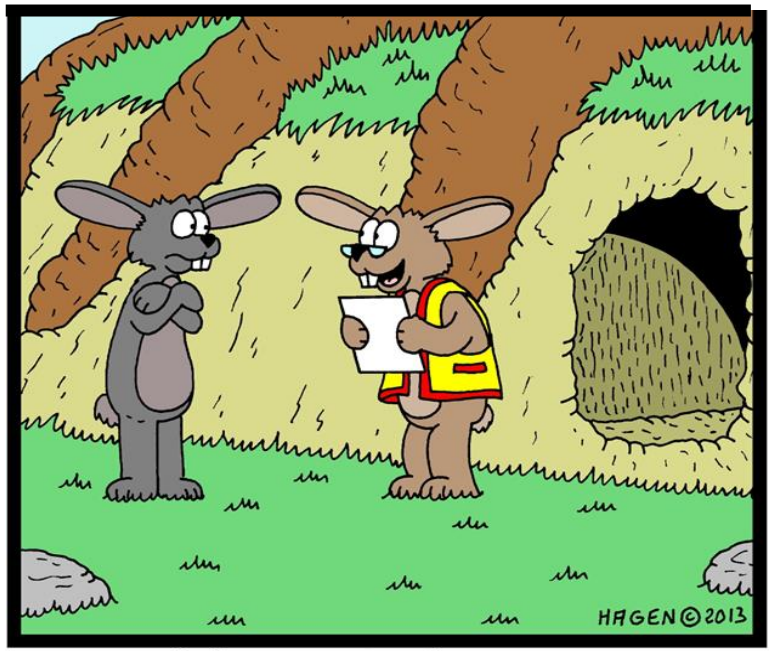
We know what doesn't work…but we keep doing it anyway

Four rabbit holes:

- Common CG traps
- Suggestions for building bridges

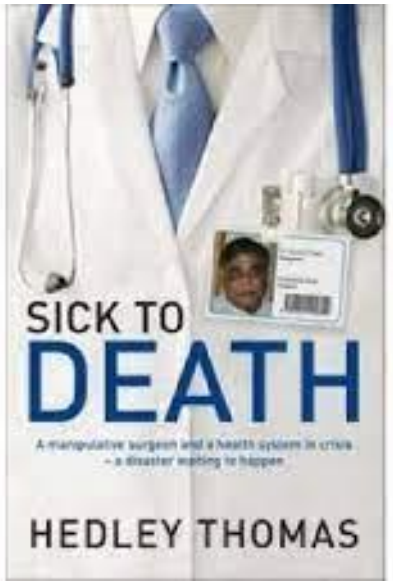


No finger pointing here…



Drill down AICG 'Four Clinical Governance Rabbit Holes' paper available – more pointers on how you can become a *'CG rabbit hole avoidance specialist*'.

Health and Human Services' long and winding quality path - 1995 to…???



Four ‘rabbit hole’ reasons (of many)

1. Activity without Purpose

2. Process before People

3. Prioritising Passivity

4. Confusing Fads with Foundations

Why these?

- Easy to fall into – hard to escape from
- Align with the literature and public inquiry findings on clinical governance failures and fault lines
- Waste time, energy and $$$
- Avoidable – through committed and focused board and executive leadership
- Lived experience

1. Activity Without Purpose

CG became all about following directions… and not about the destination

What's the point?

- "A lot of what we do [in quality management] seems to just be done for the doing" (Clinical leaders)
- "I'm so busy trying to meet compliance requirements, I question if what I am doing is actually improving care delivery." (Front line staff)

Leggat and Balding, 2018. La Trobe University Strategic Quality System Research 2015-2017.

Activity without clear purpose…that's like…

We know the importance of a ‘flag on the hill’ for quality care…

University of Leicester

‘A positive relationship exists between strategic goal setting and organisational performance.

Organisational and individual goals for quality care and services are found in higher performing health services.’

(Dixon-Woods, McNicol & Martin 2012; Dixon-Woods et al. 2014; Ham, Berwick & Dixon 2016; Leggat and Balding, 2018.)

*‘Finding deficiencies and getting rid of them is not the way to improve **system performance**. **An improvement program should be directed at what you want, not what you don’t want.** Then design the system to get what you want.’*

(Dr Russ Ackoff)

*Leaders and followers are both following the invisible leader – the **common purpose.***

- Mary Parker Follett

Leaders need something to lead ‘towards’… (otherwise you end up in the ‘swamp’!)

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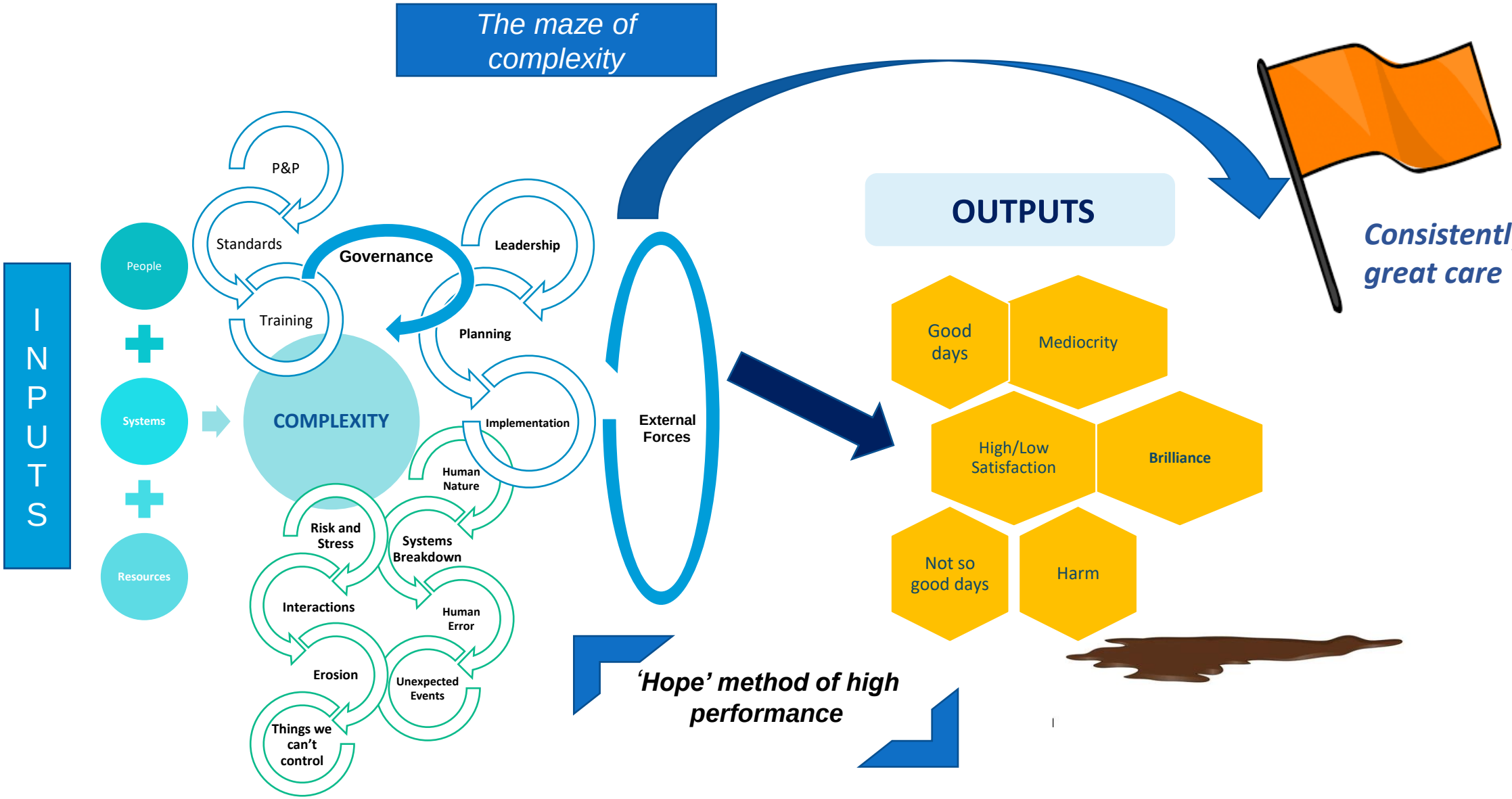
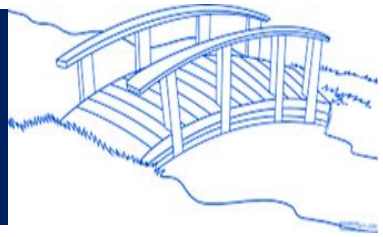


Avoid ‘Activity without Purpose’: define a high-quality service experience, and make it a board and executive priority

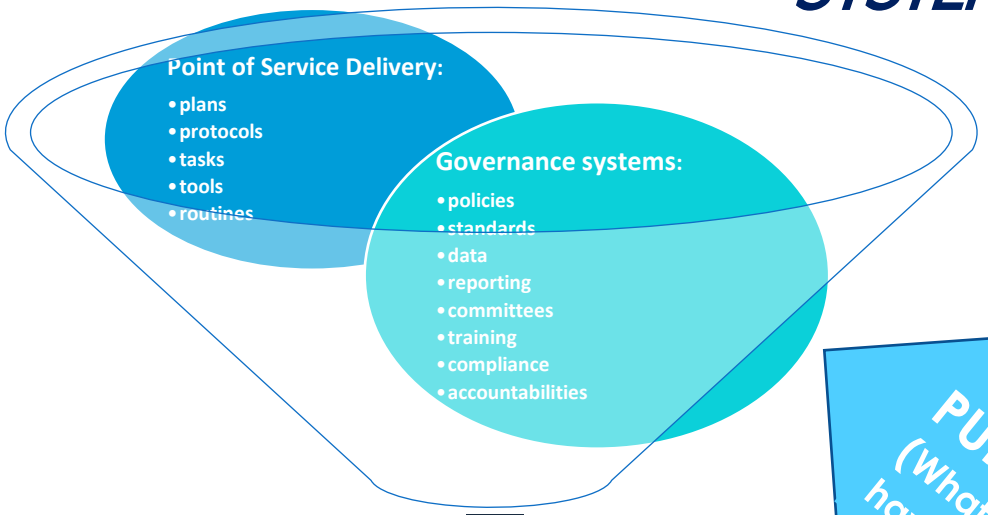


"If you want to be happy, set a goal that commands your thoughts, liberates your energy, and inspires your hopes."
- Andrew Carnegie

What do human beings want from a human service?	
Treat me like a dignified, respected individual and support my goals and needs	**INDIVIDUAL CARE**
Don’t harm me or make me worse	**SAFE CARE**
Do the right thing by me that gets the best possible result	**EFFECTIVE CARE**
Don’t let me fall through the cracks	**CONNECTED CARE**

2. Process before People

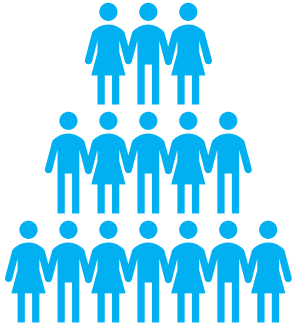
THE CG SUPPORT SYSTEM



THE QUALITY EXPERIENCE

PURPOSE (What we have to do)

PURPOSE (What we want to do)



'DOING' QUALITY

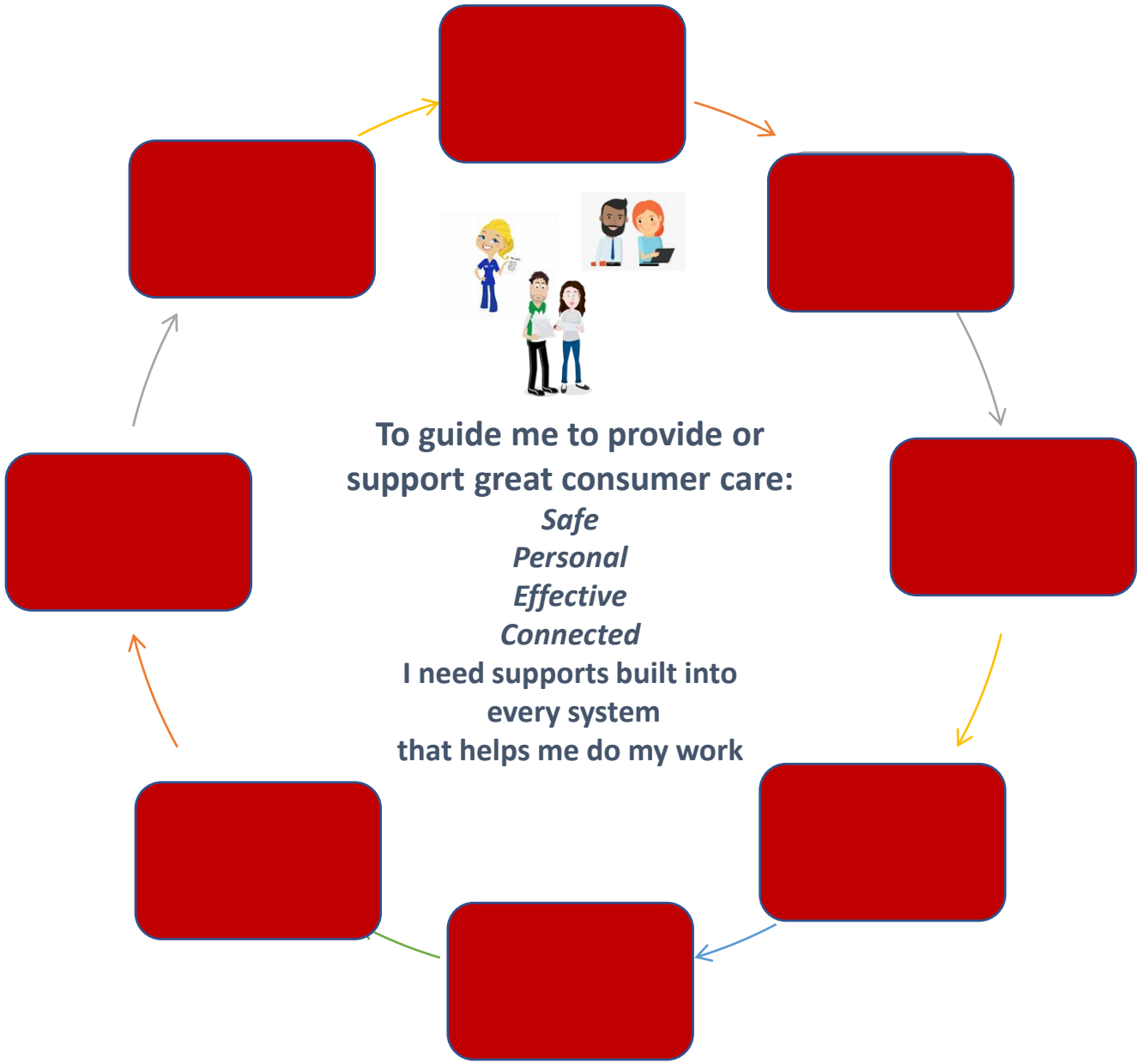
***Embed** in Systems…*

*…to **support** consistently good care*

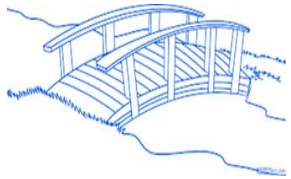
***'CREATING' QUALITY** care and services:*

- ***Individual***
- ***Safe***
- ***Effective***
- ***Connected***

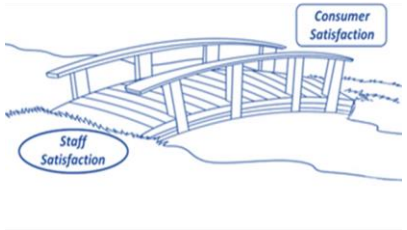
Systems must be implemented to 'wrap around' people, not the other way around



Avoid ‘Process before People’ by building a bridge between consumer and staff satisfaction



‘*No-one cares how much you know until they know how much you care.’*



Support staff with effective systems – and *build staff satisfaction* into the pursuit and achievement of quality goals

***MEANING**: how can we make the goals meaningful to staff in their daily work?*

***MASTERY**: how can we show off their skills and knowledge as they pursue the goals?*

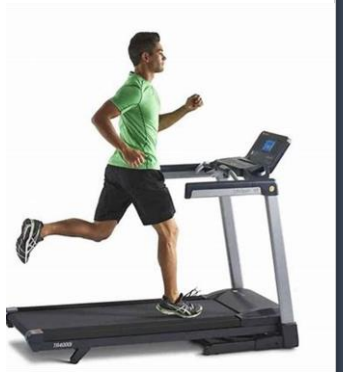
***APPRECIATIVE ACKNOWLEDGEMENT:** how can we make sure we see and appreciate goal pursuit and achievement?*

***AUTONOMY:** where can we bring in individual and team judgement and decision-making to help achieve the goals?*

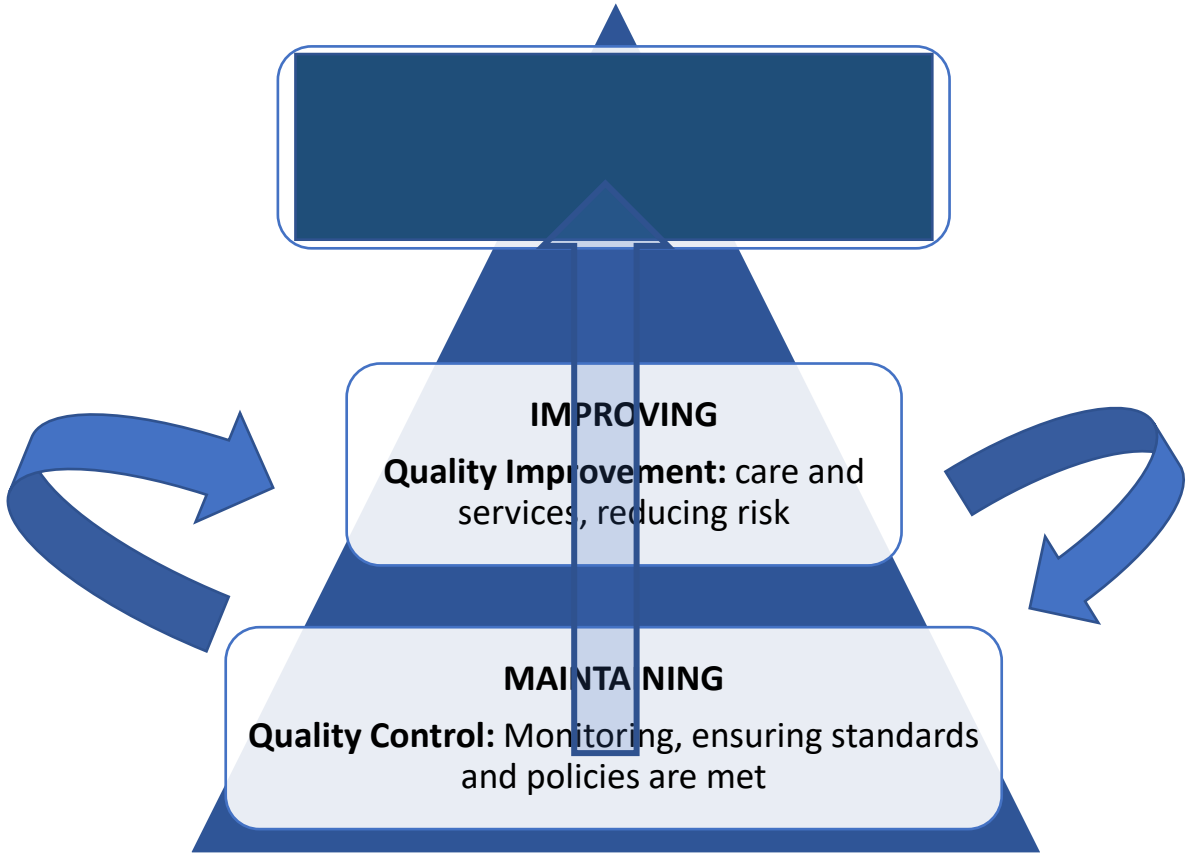
***CONNECTION**: how can we foster camaraderie and a sense of shared purpose with other staff and consumers in pursuit of the goals?*

3. Prioritising Passivity

Passive (or 'trickle down')
clinical governance:
not very useful in complex systems



We get lost in the ‘passive CG’ rabbit hole



JURAN’S QUALITY TRILOGY

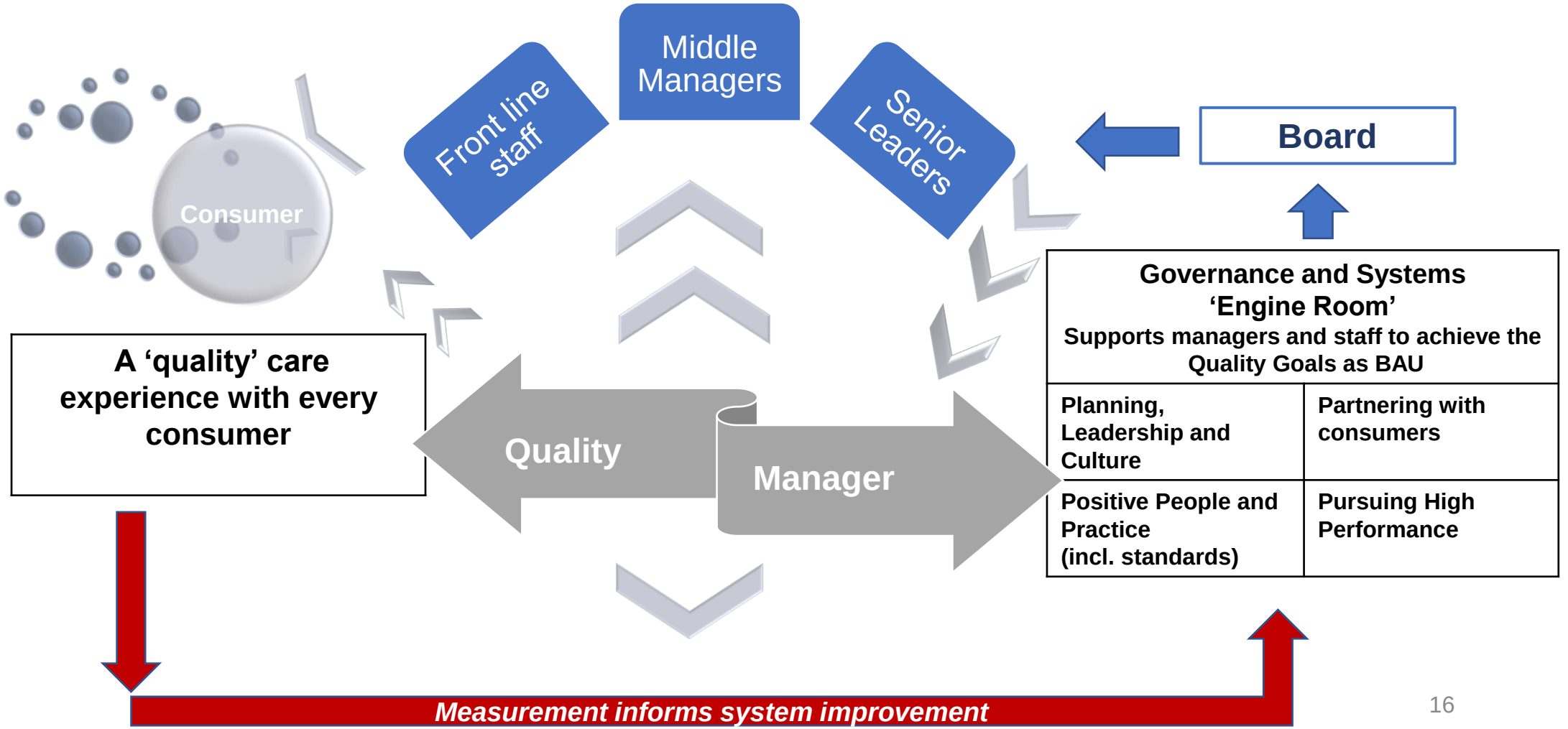
Which is often played out in quality committees…

- Looking back
- Endless monitoring
- Confusing activity with achievement
- Lack of bold decision-making for greatness

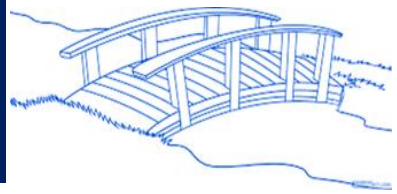
“It’s been over two weeks, and I’m starting to get concerned. Normally, when the committee jumps down a rabbit hole, they’re back in a few hours.”

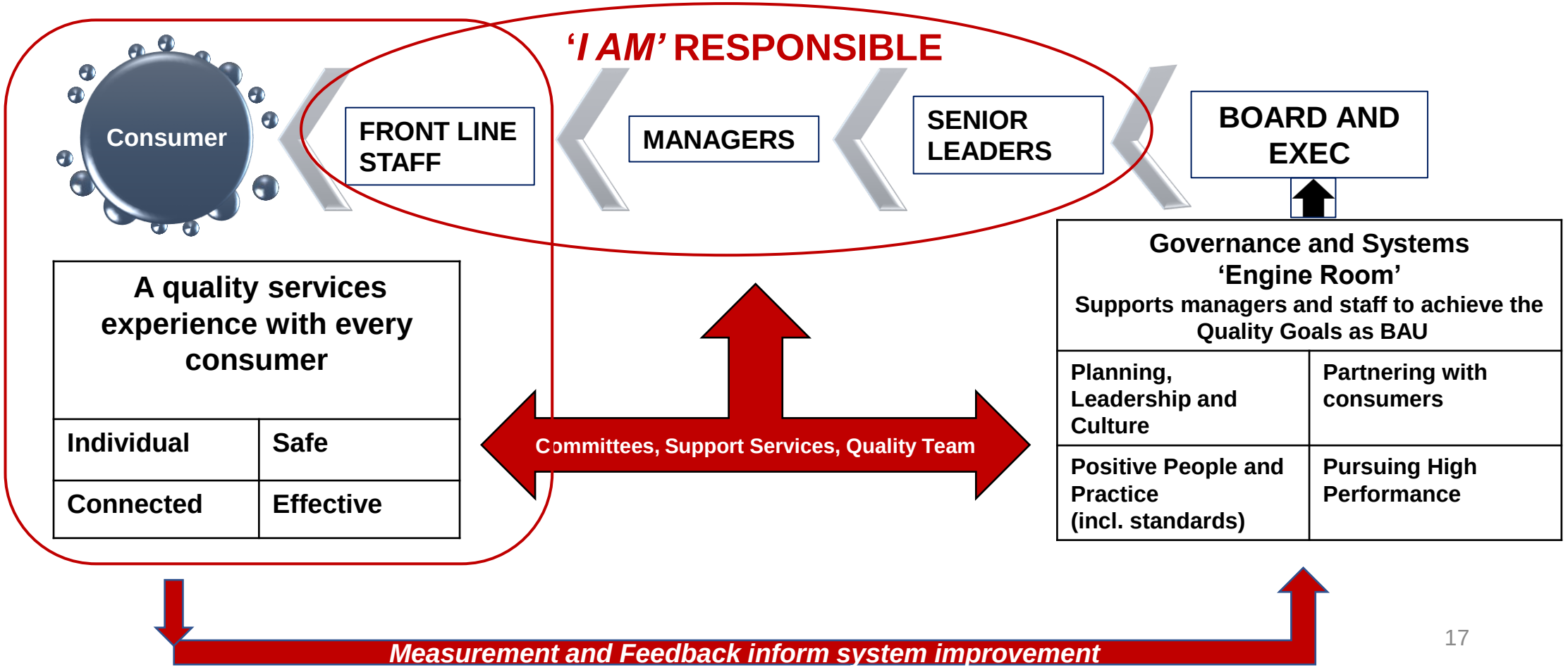
CartoonStock.com

Passive CG starts when we ‘outsource’ responsibility for care quality



Avoid 'Prioritising Passivity' by understanding what it takes to achieve consistently good care in complex systems - and implement to support line management responsibility





4. Fads before foundations

Fads are the kiss of death. When the fad goes away, you go with it.
(Conway Twitty)

Effectively implementing clinical governance foundations to support consistently high-quality services requires knowledge, skills and a toolkit

Great tools out there – from our own sectors and other industries:

- Software
- Training
- Templates
- Guidance
- Models
- Methods

But!...

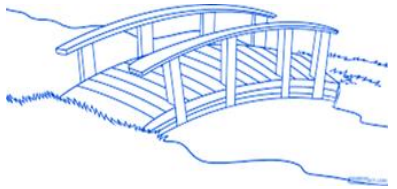
Without clear intent and purpose, there's been too much 'grab and go' and not enough 'assess and adapt':

'Studies show that some approaches borrowed from other industries may not be as effective in health care settings…' (Liberati, Peerally and Dixon-Woods, 2018.)

Tools and methods help – but there are no quick fixes. No single approach 'ensures' quality care (*busting a convenient untruth*)

Following CG Fads may sound like a quick fix, but you can end up here…

Avoid ‘Fads before Foundations’ by knowing the key CG foundations for great care - and evaluating ‘fads’ for their helpfulness in development and implementation



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Ask – will this tool/model/method help use to successfully embed the foundations of quality services (and avoid the rabbit holes?):

A. **Set clear goals for high quality services and services** and create a shared and practical understanding of what that means in practice with staff and consumers

B. **Create a positive, quality-oriented mindset and culture** that embraces the challenge of creating quality services within the real-world complexity of the environment

C. **Clarify staff roles and responsibilities for point of service quality** , support staff to enact them and to be accountable for their role

D. **Support partnering with consumers** in service improvement

E. **Develop line manager capability** to lead and pursue point of service quality goals

F. **Develop quality managers, leaders and teams** with the knowledge and skills to support line managers and staff to achieve point of service success

G. **Identify and implement the governance and operational infrastructure** required to support quality goal achievement, including the use of **standards to specifically support quality service development**

H. **Develop both responsive and proactive methods** for managing risk and creating quality services

I. **Help staff to make positive changes** that *stick and scale*

J. **Tell the story of your care and service quality** through valid, reliable, subjective and objective data.

Help is at hand! Haul your organisation out of the rabbit holes – or avoid them in the first place!

Get your copy of the drill down 'CG Rabbit Holes' paper from the Australasian Institute of Clinical Governance

And - jump on my website for a free Quality System Assessment checklist

www.cathybalding.com

www.noharmdonepodcast.com

OVERVIEW

All human service sectors experience turning points. The 1990s was a decade of revelation about poor healthcare quality, identified and reported in major studies of adverse events and public inquiries across the world. The initial shock waves evolved into a care safety revolution, supported by the introduction of clinical governance. A quarter of a century later, the outcomes of the Aged Care Quality and Safety Royal Commission are having a similar impact in aged care, with a stream of legislation and innovations challenging aged care providers to re-set their approach to creating and maintaining quality care.

The financial cost of suboptimal care to consumers and organisations is significant (ACSQHC, 2019.) Ineffective clinical governance processes also waste time, energy and resources. Expectations are growing that aged care will develop more sophisticated, whole-of-organisation approaches to improving point of care quality. The

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THANKYOU!

Join AICG for resources to accelerate your clinical governance expertise and effectiveness:

- Videos, tools and information on the **eight clinical governance tasks for success**
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